New Jersey Department of Children and Families Policy Manual

Manual:	CP&P	Child Protection and Permanency	Effective Date:
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Chapter:	A	Child Fatalities and Near Fatalities	7-21-2014
Subchapter:	1	Child Fatalities and Near Fatalities	
Issuance:	100	**Child Fatality and Near Fatality Reporting**	

Purpose

A child fatality or near fatality of a child is a significant event, the circumstances of which needs to be known at various administrative levels within DCF operations. The gathering of pertinent information, in-depth case conferencing, and staff support (technical and emotional) comprise the essential elements in the management of the Department of Children and Families' response to the fatality or near fatality of a child.

Definitions

A **"Reportable Fatality"** means the death of a child:

- Who was under CP&P supervision at the time of death, regardless of the cause of death;
- Who was not under CP&P supervision at the time of death but the death appears to have been due to suspected or confirmed child abuse or neglect by his or her parent or caregiver.

A "**Near Fatality**" means that a child was placed in serious or critical condition as the result of an act of abuse or neglect. The child's being placed in serious or critical condition must be classified by the treating physician, evidenced in the medical chart, or reflected in the hospital record. A medical provider's determination that the child is in serious or critical condition shall be accepted without further assessment by CP&P; if the provider or hospital uses different terminology to describe patient conditions, CP&P shall rely on the standard definitions provided by the American Hospital Association:

- **"Serious Condition"** means that the patient's vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
- **Critical Condition**" means that the patient's vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.

Note: A "critical incident" is NOT reported as a "near fatality." See definition of "critical incident" at CP&P-IX-D-1-100.

An **"Oral Preliminary Report"** means information given by the Local Office Manager (or the Regional Supervisor, in institutional abuse/neglect investigations) to DCF administrative staff, as initial notification of a reportable fatality or the near fatality of a child.

Immediate Oral Notifications

Child fatalities and near fatalities require immediate oral notification (by telephone or in person), from the field office DCF employee first becoming aware of the incident, through the normal chain of command, to the Local Office Manager or IAIU Regional Supervisor, who initiates immediate notifications within DCF. The Local Office Manager immediately notifies the Area Director.

Child fatalities and near fatalities that come to the attention of staff during non-business hours are reported to the State Central Registry (SCR). The Screener handling the call creates a Screening Summary (DCF Form 1-1) and assigns it immediately to the SPRU Worker, if appropriate, and, whenever possible, notifies the SPRU Supervisor or IAIU After-Hours Supervisor. The SCR Screener consults the on-duty Supervisor at SCR and forwards a copy of the Screening Summary to the Reportable Incident Administrator e-mail account at SCR. The on-call SPRU Worker conferences the report with the on-call SPRU Supervisor and/or IAIU After-Hours Supervisor. The SPRUIAIU After-Hours Supervisor notifies the Local Office Manager or Regional Supervisor after hours. The Local Office Manager/IAIU Regional Supervisor makes the oral preliminary report.

Content of the Oral Preliminary Report

The contents of the Office Manager's oral preliminary report include:

- Name(s) of child victim(s)subject of incident
- Child's date of birth or age

- Child's sex
- Names of others involved, including siblings
- Nature of incident, circumstances, and cause(s) of fatality or near fatality
- Date of incident/death
- Case status (open, date closed, never known to CP&P)
- Identify who is conducting the investigation - LO, IAIU, or SPRU
- Office contact person
- LOIAIU supervising the case and/or investigation
- Name of physician/medical facility certifying child's condition meets criteria for a near fatality or reportable death
- Law enforcement involvement - local police, State Police, County Prosecutor, Medical Examiner
- Media involvement - news reporters, newspapers, TV stations, Internet sites

Initial Written Report

Child fatalities and near fatalities require written notification from the Area Office where the incident occurred. The Local Office is responsible for assisting the Area Director/Designee in completing CP&P Form 21-11, Child Fatality/Near Fatality Report. This initial report must be completed within hours of receipt of the report from SCR.

If a child fatality or near fatality occurs over the weekend, the report is due by the close of business on Monday.

If a child fatality or near fatality occurs on a State holiday, the report is due by the close of business on the next working day.

Follow-up Reports

Continuous follow-up is needed after a child fatality or near fatality occurs.

CP&P Form 21-12, Child Fatality/Near Fatality Update Summary Report, is completed within 14 calendar days of receipt of the report from SCR, in follow up to CP&P Form 21-11, Child Fatality/Near Fatality Report.

The CP&P Form 21-12 is prepared by the Area Director or Designee (with the assistance of the Local Office). Upon completion of the form, the Area Director forwards the form to the Office of the CP&P Director, who forwards it to other relevant staff, as deemed appropriate by the CP&P Director.

CP&P Form 21-13, Child Fatality/Near Fatality Concluding Summary, is completed immediately following the completion of the investigation.

The CP&P Form 21-13 is prepared by the Area Director or Designee (with the assistance of the Local Office). Upon completion of the form, the Area Director forwards the form to the Office of the CP&P Director, who forwards it to other relevant staff, as deemed appropriate by the CP&P Director.

Note: The Area Director notifies the CP&P Director prior to entering the investigation finding determination.

Casework and Staff Support

The child fatality or near fatality is conferenced by the Worker or IAIU Investigator and his or her Supervisor and Casework Supervisor as soon as possible following the initial oral reports made to DCF administrative staff. Conferencing continues at regular intervals, as necessary.

The purposes of the conferences are to:

- Review the case status at the time of the child's death or near fatality;
- Review/update the case status as the investigation proceeds;
- Assess the safety of surviving siblings and other children in the home/facility, or under the care of the parent/caregiver;
- Develop strategies for addressing the family's needs (such as helping to make funeral arrangements for the deceased child);
- Gather relevant information to facilitate timely and accurate case recording;
- Assist in completing CP&P Form 21-11, Child Fatality/Near Fatality Report, within 24 hours of the incident;
- Assist in completing CP&P Form 21-12, Child Fatality/Near Fatality Update Summary, within 14 calendar days of the initial report;

- Assist in completing CP&P Form 21-13, Child Fatality/Near Fatality Concluding Summary, immediately following the completion of the investigation.

In addition, these conferences serve as a means of observing and evaluating the emotional impact a child's fatality or near fatality may be having on individual staff members, and how a plan may be developed to meet their needs. See CP&P-V-A-6-600, CP&P Staff Reactions to the Death of a Child.

IAIU Investigations

The fatality or near fatality of a child residing in a group home, shelter, congregate care facility, or resource family home, that is alleged to have been caused by child abuse or neglect, is investigated by the DCF Institutional Abuse Investigation Unit (IAIU), whether or not the child was known to CP&P. SPRU starts the investigation, if the child fatality is reported after hours.

If the child was under CP&P supervision at the time of death/incident, or other members of the child's immediate family are under CP&P supervision, the IAIU Investigator may seek assistance from the assigned CP&P Worker.

Other Child Fatalities

The State Central Registry (SCR) is often contacted about child fatalities that are not reportable fatalities. Such reports may come from law enforcement authorities, such as the Medical Examiner or the County Prosecutor, calling for collateral information, to determine whether CP&P had prior history with the child/family.

If there are evident child welfare concerns related to the child fatality, consider whether a case should be opened by CP&P for a service assessment regarding the other/surviving children in the family/household.

If, upon careful screening, it appears that the child fatality does not meet the criteria for a reportable fatality or a CWS referral, the SCR Screener records the child death in NJ SPIRIT, at the Intake Window, as an Information and Referral (I&R) intake.

The SCR Screener advises the caller what role CP&P will play, if any, in follow up to his or her report of the death of a child.

Child Fatality and Near Fatality Review Board

N.J.S.A. 9:6-8.88 et seq. establishes the Child Fatality and Near Fatality Review Board, to review the fatalities and near fatalities of children in New Jersey, to identify their causes. N.J.A.C. 10:16, DCF Child Fatality and Near Fatality Review Board, provides procedures followed by the Board, to review all situations involving children presently or formerly (within the past 12 months) under CP&P supervision, who:

a) Are alleged to have died due to abuse or neglect; or

b) Were the subject of a near fatality that was alleged to have been due to abuse or neglect.

The Board may review other situations, at the discretion of the Chairperson or the CP&P Director.

The Board is multidisciplinary in nature, and serves to develop recommendations for broad-based system, policy and legislative revisions and community remedies. The Board promotes prevention of near fatalities or fatalities of vulnerable children, and seeks the involvement of many different professionals and agencies which provide services to children. A report of the Board's discussion is limited to internal use by DCF, and is not to be released outside of the Department.

The Board makes its Annual Report available to the public. The Annual Report does not contain any direct or indirect identifying information about child victims or their families, or DCF casework staff.

Related Policy

- CP&P-IX-G-1-100, see section: Information to be Disclosed to the Public/Media by the CP&P Director/DCF Office of Public Information about a Child Fatality or Near Fatality Resulting from Child Abuse/Neglect, and section: N.J.S.A. 9:6-8.88 to 8.96-Child Fatality and Near Fatality Review Board
- CP&P-IX-D-1-100, Critical Incident Reporting
- CP&P-II-C-4-100, see section G: Cooperation between CP&P and County Medical Examiners
- CP&P-II-D-2-200, Administrative Support to SPRU
- CP&P-V-A-6-200, Death of a Child Under Supervision
- CP&P-V-A-6-400, Funeral, Burial and Bereavement Arrangements

- CP&P-II-E-1-100, Child Death (as a child abuse/neglect allegation, subject to CPS investigation, from the Allegation-Based System)